



Government of the District of Columbia Department of Health

Health Regulation and Licensing Administration Medical Marijuana Program

Refer to the Application Instructions when completing this form. Type or block print only. Do not use felt-tip pen

Patient Name				
	First Name	Middle Initi	al	
□Initial				
□Renewal	Last Name	Suffix(i.e.,	Jr., Sr., II,III)	
Social Security Number	*if applicant does not have a Social Security Number, see application instructions			
Date of Birth	Month Day	*If patient is under 18, us	se minor patient app	lication
Mailing Address It is your responsibility to notify the Department of all address	Street (P .O. Box NOT	Γ acceptable)		Apt/Suite
changes	City	Stat	te	Zip Code
	()			
	Phone Number		— Email Addı	ress
Physician Name and Office Address Information	First Name	Mid	dle Initial	_
	Last Name	Suffix(i.e.,	Jr., Sr., II,III)	
	Street (P .O. Box NOT acceptable)			Apt/Suite
	City	Stat	te	Zip Code
	Phone Number Email Address		ress	

Dispensary				
(Select one)	O Capital City1334 N. Capitol Street NW, Washington, DC 20002			
	O Metropolitan Wellness409 8 th Street SE, Washington , DC 20003			
	O Takoma Wellness6925 Blair Road NW, Washington, DC 20012			
	O Herbal Alternative1710 Rhode Island Avenue NW, Washington, DC 20036			
	O National Holistic Healing Center1718 Connecticut Ave. NW, Washington, DC 20009			
Patient's Attestation Signature and Date	Limitation of Liability – The District of Columbia shall not be liable to the registrant, its employees, agents, business invitees, licensees, customers, clients, family members or guests for any damage, injury, accident, loss, compensation or claim, based on, arising out of or resulting from registrant's participation in the District of Columbia's medical marijuana program, including but not limited to the following: arrest and seizure of persons and/or property, prosecution pursuant to federal laws by federal prosecutors, interruption in registrant's ability to operate its medical marijuana cultivation center and/or dispensary; any fire, robbery, theft, mysterious disappearance or any other casualty; the actions of any other registrants or persons within the cultivation center and/or dispensary. This Limitation of Liability provision shall survive expiration or the earlier termination of this registration if such registration is granted.			
	Federal Prosecution - The United States Congress has determined that marijuana is a controlled substance and has placed marijuana in Schedule I of the Controlled Substance Act. Growing, distributing, and possessing marijuana in any capacity, other than as a part of a federally authorized research program, is a violation of federal laws. The District of Columbia's law authorizing the District's medical marijuana program will not excuse any registrant from any violation of the federal laws governing marijuana or authorize any registrant to violate federal laws.			
	I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge. I acknowledge receipt and advisement of the notices above, and I agree to and accept the limitation of liability against the District. I assume any and all risk or liability that may result under the District of Columbia or federal laws arising from the possession, use, or cultivation, administration, or dispensing of medical marijuana. I understand that the medical marijuana laws and enforcement thereof of the District of Columbia and the Federal government are subject to change at any time. I sign this attestation willingly and without reservation and am fully aware of its meaning and effect.			
	Patient's Signature Date			

Remember to include:

- ✓ Two recent passport photos (2" x 2")
- ✓ Photocopy of U.S., state, or District government-issued photo ID
- ✓ Application fee (paid by Certified check, money order, or cashier's check made payable to DC Treasurer)
- ✓ 2 forms of proof of DC residency (acceptable forms of proof residency listed in application instructions)
- ✓ Electronic Physician Recommendation